HMONG COLLEGE PREP ACADEMY

1515 Brewster Street, Saint Paul, MN 55108
Office:(651) 209-8002 • Fax:(651) 289-1802
www.hcpak12.org

Annual Student Health Form

Student Name: _____ **Birth Date:** _____ ☐ **Male** ☐ **Female** **Grade:** _____ **School Year:** _____

Parent/Guardian: _____ **Phone:** _____ **Work:** _____ **Cell:** _____

Please answer ALL questions on this form and return it to school as soon as possible.

HEALTH CONCERNS: * *Submit action plan for starred conditions.*

(Please check and explain if your child has any of the following)

YES	NO	
☐	☐	Attention Deficit Hyper-Activity Disorder/ Attention Deficit Disorder (ADHD/ADD)
		☐ other social / emotional / behavioral / mental health concerns
		Describe_____
☐	☐	Allergies * to _____
		Reaction_____
☐	☐	Food Intolerance to _____
		Reaction_____
☐	☐	Asthma * or breathing problem:
		Has the asthma been diagnosed by a physician ☐ Yes ☐ No
☐	☐	Diabetes*: ☐ Type 1 ☐ Type 2
		Managed by: ☐ Diet/Activity ☐ Oral medications ☐ Insulin injections ☐ Pump
☐	☐	Seizures *:
		Type _____ Frequency _____
		Description _____ Last Seizure _____
☐	☐	Heart Condition
		Describe _____
☐	☐	Is the student pregnant? Due date _____ Does the student have children? Age of child(ren) _____
☐	☐	Concussion/ Traumatic Brain Injury
		Describe _____ Date _____
☐	☐	Recent surgeries, hospitalizations, injuries
		Describe _____
☐	☐	Implanted Devices
		What kind _____
☐	☐	Special Education/504 Plan
☐	☐	Bowel / Bladder Concerns
		Describe _____
☐	☐	Most Recent Physical Examination
		Date _____
☐	☐	Does your child have a health problem that could result in an emergency?*
		Describe_____
☐	☐	Other Health Concerns or Activity Restrictions*
		Describe_____

HEALTH CARE PROVIDERS AND INSURANCE INFORMATION (Note: section below MUST be completed):

Health Care Provider's Clinic

Name: _____ Name of doctor/provider: _____

Address: _____ Phone: _____ Hospital Preference: _____

Dental Clinic

Name: _____ Name of doctor/provider: _____

Address: _____ Phone: _____

Health Insurance

Is the student cover by Health Insurance? ☐ Yes ☐ No Insurance Name: _____

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Vision

- ☐ Glasses/contacts prescribed
- ☐ Wears glasses/contacts all the time
- ☐ Wears glasses in classroom only
- ☐ Request assistance obtaining glasses
- ☐ No vision problem

Hearing

- ☐ Frequent ear infections (3 or more per year in past year)
- ☐ Has ear tube(s)
- ☐ Hearing loss (Circle): right ear / left ear
- ☐ Hearing aid(s) (Circle): right ear / left ear
- ☐ No hearing problem

MEDICATIONS:

List **ALL** medications that your child takes daily or when needed. Consent is **REQUIRED** for **ALL** medication taken at school, including over the counter medications. **BOTH HEALTH CARE PROVIDER AND PARENT MUST SIGN THE CONSENT.** A new consent is needed each school year. Forms are available in the health office.

Medication Name	Purpose	Dose	Needed during school? How often?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I attest to the information provided. I acknowledge that it is my responsibility to inform the school of any changes to the health status of this student including health conditions, needs, medications, and/or allergies. I understand and agree that this student may receive a routine screening for any vision and hearing deficiencies. I will comply with all school illness and medication policies. Furthermore, I give permission for school health staff to confidentially exchange health information - both within the school as well as with outside health care providers - for use in meeting this student's health and educational needs in school.

This health information may be shared with HCPA staff members as needed. If you do not want this health information shared, please contact Health Coordinator at 651-209-8004.

Parent/Guardian signature_____ **Date** _____